2011 Benefits

Lake County Board of County Commissioners 64550

The Lake County Board of County Commissioners believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

	BlueChoice	BlueCare
COST SHARING	730	15
Maximums shown are Per Benefit Period (BPM) unless	PPO	НМО
noted		NI de la
Deductible (DED) (Per Person/Family Agg)	Φ 7 50 / ΦΩ Ω50	Not Applicable
In-Network Out-of-Network	\$750 / \$2,250 Combined w/In-Ntwk	
Coinsurance (Member Responsibility)	Combined Will-NWK	Not Applicable
In-Network	20%	Tiot / ipplicable
Out-of-Network	40%	
Out of Pocket Maximum (Per Person/Family Agg)	Includes only Coins; Excludes Rx	Includes all Copays (including Rx)
In-Network	\$2,000 / \$6,000	\$2,000 / \$4,000
Out-of-Network	Combined w/In-Ntwk	Not Applicable
Lifetime Maximum	No Maximum	No Maximum
PROFESSIONAL PROVIDER SERVICES		
Allergy Injections (for testing, see place of service)		
In-Network Family Physician	\$0	\$0
In-Network Specialist Out-of-Network	\$0 DED + 40%	\$0 Not Covered
E-Office Visit Services	DED + 40%	inot Covered
In-Network Family Physician	\$20	\$20
In-Network Specialist	\$35	\$35
Out-of-Network	DED + 40%	Not Covered
Office Services		
In-Network Family Physician	\$20	\$20
In-Network Specialist	\$35	\$35
Out-of-Network	DED + 40%	Not Covered
Provider Services at Hospital and ER In-Network Family Physician	DED + 20%	\$0
In-Network Specialist	DED + 20%	\$0 \$0
Out-of-Network	DED + 40%	Not Covered
Provider Services at Other Locations	222 : 1676	1101 0010.00
In-Network Family Physician	DED + 20%	\$0
In-Network Specialist	DED + 20%	\$0
Out-of-Network	DED + 40%	Not Covered
Radiology, Pathology and Anesthesiology Provider		
Services at Hospital or Ambulatory Surgical Center In-Network Specialist	DED + 20%	\$0
Out-of-Network	DED + 20% DED + 40%	Not Covered
PREVENTIVE CARE	DED 1 4070	146t Covered
Adult Wellness Office Services		
In-Network Family Physician	\$20	\$20
In-Network Specialist	\$35	\$35
Out-of-Network	40% (No DED)	Not Covered
Colonoscopies Routine screening only for age 50+ covered at	, i	
100% of allowed amount; In and Out of Network. With diagnosis,		
subject to applicable deductible, coinsurance or copays. In-Network	20% (No DED)	See Location of Service
Out-of-Network	40% (No DED)	Not Covered
Mammograms (Routine and Dx)	10,0 (110 525)	1.01 2010100
In-Network	\$0	\$0
Out-of-Network	\$0	Not Covered
Well Child Office Visits (No BPM**)		
In-Network Family Physician	\$0	\$0
Well Child Office Visits, continued	# 2	0 0
In-Network Specialist	\$0 40% (No DED)	\$0 Not Covered
Out-of-Network EMERGENCY/URGENT/CONVENIENT CARE	40% (No DED)	Not Covered
	No Mardanias (see de la	No Marian es (se se de)
Ambulance In-Network	No Maximum (per day) DED + 20%	No Maximum (per day) \$0
Out-of-Network	In-Ntwk DED + 20%	Not Covered
Cat of Hotwork	III I THOUGH DED 1 20/0	140t Govered

Maximums shown are Per Benefit Period (BPM) unless noted		BlueChoice	BlueCare
Maximums shown are Per Benefit Period (BPM) unless noted	COST SHARING		
Convenient Care Centers (CCC) In-Network		PPO	НМО
In-Network S20	· · · · · · · · · · · · · · · · · · ·		
DED + 40% Not Covered		·	
Emergency Room Facility Services (also see Professional Provider Services) In-Network		·	•
Galos see Professional Provider Services) In-Network		DED + 40%	Not Covered
In-Network			
Urgent Care Centers (UCC) In-Network \$20		\$50	\$100
In-Network			
Out-of-Network	Urgent Care Centers (UCC)		
FACILITY SERVICES - HOSP/SURG/ICL/IDTF Unless otherwise noted, physician services are in addition to facility services. See Professional Provider Services. Ambulatory Surgical Center In-Network DED + 20% S200 Not Covered In-Network DED + 40% Not Covered In-Network DED + 40% Not Covered In-Network (Quest Labs) Not Covered Independent Clinical Lab In-Network (Guest Labs) Out-of-Network Description of the provider Services (Provider Services) In-Network (Covered Description of the provider Services) In-Network - Advanced Imaging Services (AIS) In-Network - Advanced Imaging Services (AIS) S35 S200 In-Network - Other Diagnostic Services (e.g. X-ray) S35 S15 Not Covered Inpatient Hospital (per admit) In-Network Order Diagnostic Services (e.g. X-ray) DED + 40% Not Covered Inpatient Hospital (per admit) In-Network DED + 20% S200 per Day up to \$1,000 Not Covered Outpatient Hospital (per visit) In-Network DED + 40% Not Covered Outpatient Hospital (per visit) In-Network DED + 40% Not Covered DED + 40% Not Covered In-Network DED + 40% Not Covered DED + 40% Not Covered In-Network DED + 40% Not Covered Physician or Specialist Sp		·	* T T
Unless otherwise noted, physician services are in addition to facility services. See Professional Provider Services. Ambulatory Surgical Center In-Network Out-of-Network Independent Clinical Lab In-Network (Quest Labs) Out-of-Network Independent Diagnostic Testing Facility - Xrays and AlS (Includes Physician Services) In-Network - Advanced Imaging Services (AIS) In-Network - Advanced Imaging Services (AIS) In-Network - Other Diagnostic Services (AIS) In-Network - Other - Other - Other Diagnostic Services (AIS) In-Network - Other - Oth		DED + 40%	Not Covered
10	FACILITY SERVICES - HOSP/SURG/ICL/IDTF		
Ambulatory Surgical Center In-Network			
In-Network			
Out-of-Network DED + 40% Not Covered		DED + 20%	\$200
Independent Clinical Lab In-Network (Quest Labs) 20% (No DED) \$0		7.7.7	•
Out-of-Network			
Independent Diagnostic Testing Facility - Xrays and AIS (Includes Physician Services) In-Network - Advanced Imaging Services (AIS) \$35 \$200 \$35 \$15	/		and the control of th
Xrays and AlS (Includes Physician Services) In-Network - Advanced Imaging Services (AIS) \$35 \$200 In-Network - Advanced Imaging Services (e.g. X-ray) \$35 \$35 In-Network - Other Diagnostic Services (e.g. X-ray) \$35 \$35 In-Network - Other Diagnostic Services (e.g. X-ray) \$35 \$15 In-Network - Out-of-Network DED + 40% Not Covered In-Network DED + 20% \$200 In-Network DED + 40% Not Covered In-Network Physician or Specialist \$50 \$0 In-Network Physician or Specialist \$20 / \$35 In-Network Physician or Specialist \$20 / \$35 In-Network Provider DED + 40% Not Covered In-Network Provider DED + 40% Not Covered In-Network Provider DED + 40% Not Covered In-Network Physician DED + 40% Not Covered In-Network Physician DED + 20% \$100 In-Network Provider DED + 40% Not Covered In-Network Physician DED + 20% \$100 In-Network Provider DED + 40% Not Covered In-Network Physician DED + 20% \$100 In-Network Phys		40% (No DED)	Not Covered
In-Network - Advanced Imaging Services (AIS) (NRI) MRA, PET, CT, Nuclear Medicine) In-Network - Other Diagnostic Services (e.g. X-ray) \$35 \$15 Not Covered			
(MRI, MRA, PET, CT, Nuclear Medicine) In-Network - Other Diagnostic Services (e.g. X-ray) \$35 DED + 40% Not Covered		\$35	\$200
Out-of-Network DED + 40% Not Covered Inpatient Hospital (per admit) In-Network DED + 20% \$200 per Day up to \$1,000 Not Covered DED + 40% Not Covered DED + 40% Not Covered DED + 40% Not Covered Not Covered DED + 40% Not Covered Not Covered DED + 40% Not Covered DED + 40% Not Cov	(MRI, MRA, PET, CT, Nuclear Medicine)	·	<u></u>
In-Network	, , ,	·	
In-Network		DED + 40%	Not Covered
Out-of-Network DED + 40% Not Covered Outpatient Hospital (per visit) DED + 20% \$200 Out-of-Network DED + 40% Not Covered Therapy at Outpatient Hospital DED + 20% \$20 In-Network DED + 40% Not Covered MENTAL HEALTH AND SUBSTANCE ABUSE DED + 40% Not Covered Inpatient Hospitalization DED + 20% \$200 per Day up to \$1,000 In-Network DED + 40% Not Covered Out-of-Network DED + 20% \$200 per Day up to \$1,000 Out-of-Network DED + 40% Not Covered Provider Services at Hospital and ER BED + 20% \$200 Not Covered Provider Services at Hospital and ER \$50 \$0 Not Covered Physician Office Visit \$50 \$0 Not Covered Physician Office Visit \$20 / \$35 \$20 / \$35 \$20 / \$35 Out-of-Network Provider DED + 40% Not Covered Emergency Room Facility Services (per visit) BED + 40% Not Covered In-Network \$50 \$100		DED + 20%	\$200 per Day up to \$1,000
Outpatient Hospital (per visit) DED + 20% \$200 Out-of-Network DED + 40% Not Covered Therapy at Outpatient Hospital DED + 20% \$20 In-Network DED + 20% \$20 Out-of-Network DED + 40% Not Covered MENTAL HEALTH AND SUBSTANCE ABUSE In-Network Hospitalization In-Network DED + 20% \$200 per Day up to \$1,000 Out-of-Network DED + 40% Not Covered Out-of-Network DED + 20% \$200 Out-of-Network DED + 20% \$200 Out-of-Network DED + 20% Not Covered Provider Services at Hospital and ER \$50 \$0 In-Network Family Physician or Specialist \$50 \$0 Out-of-Network Provider DED + 40% Not Covered Emergency Room Facility Services (per visit) In-Network \$50 \$100 In-Network \$50 \$100 Out-of-Network \$50 \$100 Provider Services at Locations other than Hospital and ER \$50 \$100 In-			
In-Network		DED 1 1070	Not Governa
Therapy at Outpatient Hospital In-Network Out-of-Network MENTAL HEALTH AND SUBSTANCE ABUSE Inpatient Hospitalization In-Network Out-of-Network Out-of-Network Out-of-Network Out-of-Network In-Network Out-of-Network Out-of-Network Out-of-Network Provider Services at Hospital and ER In-Network Family Physician or Specialist Out-of-Network Provider Physician Office Visit In-Network Family Physician or Specialist Out-of-Network Provider Physician Office Visit In-Network Family Physician or Specialist Out-of-Network Provider Emergency Room Facility Services (per visit) In-Network Out-of-Network S50 S100 S0 Not Covered Physician Office Visit In-Network Family Physician or Specialist Out-of-Network Provider Emergency Room Facility Services (per visit) In-Network Out-of-Network S50 S100 S100 Provider Services at Locations other than Hospital and ER In-Network Family Physician DED + 20% S0 S0 S100 S100 S100 S100 S100 S100 S		DED + 20%	\$200
In-Network		DED + 40%	Not Covered
Out-of-Network DED + 40% Not Covered MENTAL HEALTH AND SUBSTANCE ABUSE Inpatient Hospitalization DED + 20% \$200 per Day up to \$1,000 Out-of-Network DED + 40% Not Covered Outpatient Hospitalization (per visit) DED + 20% \$200 In-Network DED + 20% \$200 Out-of-Network DED + 40% Not Covered Provider Services at Hospital and ER \$50 \$0 In-Network Family Physician or Specialist \$50 Not Covered Physician Office Visit \$20 / \$35 \$20 / \$35 In-Network Family Physician or Specialist \$20 / \$35 \$20 / \$35 Out-of-Network Provider DED + 40% Not Covered Emergency Room Facility Services (per visit) \$50 \$100 In-Network \$50 \$100 Out-of-Network \$50 \$100 Provider Services at Locations other than Hospital and ER \$50 \$100 In-Network Family Physician DED + 20% \$0		DED - 000/	# 00
Inpatient Hospitalization			
In-Network Out-of-Network Out-of-Network Out-of-Network Out-of-Network Out-of-Network Out-of-Network DED + 20% DED + 40% Not Covered Second Secon		DED + 40%	Not Covered
In-Network Out-of-Network Out-of-Network Outpatient Hospitalization (per visit) In-Network Out-of-Network Out-of-Network Out-of-Network Out-of-Network Provider Services at Hospital and ER In-Network Family Physician or Specialist Out-of-Network Provider Specialist In-Network Family Physician or Specialist Out-of-Network Provider DED + 40% Not Covered **So** **So*			
Out-of-Network Outpatient Hospitalization (per visit) In-Network Out-of-Network DED + 20% Out-of-Network DED + 40% Not Covered \$200 \$200 Not Covered Provider Services at Hospital and ER In-Network Family Physician or Specialist Out-of-Network Provider Physician Office Visit In-Network Family Physician or Specialist Out-of-Network Provider Emergency Room Facility Services (per visit) In-Network Out-of-Network Out-of-Network Provider Services at Locations other than Hospital and ER In-Network Family Physician PED + 20% Not Covered \$20 / \$35 \$20 / \$35 \$20 / \$35 \$20 / \$35 \$100 \$100 Provider Services at Locations other than Hospital and ER In-Network Family Physician DED + 20% \$0		DED + 20%	\$200 per Day up to \$1,000
In-Network Out-of-Network Provider Services at Hospital and ER In-Network Family Physician or Specialist Out-of-Network Provider Physician Office Visit In-Network Family Physician or Specialist Out-of-Network Provider Physician Office Visit In-Network Family Physician or Specialist Out-of-Network Provider Emergency Room Facility Services (per visit) In-Network Out-of-Network Out-of-Network Provider Services at Locations other than Hospital and ER In-Network Family Physician DED + 20% \$20 / \$35 S20 / \$35 Not Covered \$100 \$100 \$100 \$100 \$100 \$100 \$100 \$1	Out-of-Network	7.7.7	
Out-of-Network Provider Services at Hospital and ER In-Network Family Physician or Specialist Out-of-Network Provider Physician Office Visit In-Network Family Physician or Specialist Out-of-Network Provider Physician Office Visit In-Network Family Physician or Specialist Out-of-Network Provider Emergency Room Facility Services (per visit) In-Network Out-of-Network Provider Services at Locations other than Hospital and ER In-Network Family Physician DED + 20% Not Covered \$20 / \$35 DED + 40% Not Covered \$20 / \$35 Services Services Services (per visit) In-Network \$50 \$100 \$100 \$100 \$100 \$100 \$100 \$100			
Provider Services at Hospital and ER In-Network Family Physician or Specialist \$50 \$0 Out-of-Network Provider \$50 Not Covered Physician Office Visit In-Network Family Physician or Specialist \$20 / \$35 Out-of-Network Provider DED + 40% Not Covered Emergency Room Facility Services (per visit) In-Network \$50 \$100 Out-of-Network \$50 \$100 Provider Services at Locations other than Hospital and ER In-Network Family Physician DED + 20% \$0			·
In-Network Family Physician or Specialist Out-of-Network Provider Physician Office Visit In-Network Family Physician or Specialist Out-of-Network Provider Emergency Room Facility Services (per visit) In-Network Out-of-Network Provider Services at Locations other than Hospital and ER In-Network Family Physician \$50 \$100 \$100 \$50 \$100 \$50 \$100 \$50 \$100 \$50 \$100 \$50 \$100 \$50 \$50 \$100 \$50 \$50 \$50 \$50 \$50 \$50 \$50 \$50 \$50 \$		DED + 40%	Not Covered
Out-of-Network Provider \$50 Not Covered Physician Office Visit In-Network Family Physician or Specialist \$20 / \$35 \$20 / \$35 Out-of-Network Provider DED + 40% Not Covered Emergency Room Facility Services (per visit) In-Network \$50 \$100 Out-of-Network \$50 \$100 Provider Services at Locations other than Hospital and ER In-Network Family Physician DED + 20% \$0		\$50	\$0
Physician Office Visit In-Network Family Physician or Specialist Out-of-Network Provider Emergency Room Facility Services (per visit) In-Network Out-of-Network Store Services at Locations other than Hospital and ER In-Network Family Physician Store Services at Locations other than Hospital and ER DED + 20% \$20 / \$35 Not Covered \$100 \$100 \$100 \$100 \$100 \$100 \$100 \$1			
Out-of-Network Provider Emergency Room Facility Services (per visit) In-Network Out-of-Network Provider Services at Locations other than Hospital and ER In-Network Family Physician DED + 40% Not Covered \$100 \$100 \$100 \$100 \$100 \$100 \$100 \$1			
Emergency Room Facility Services (per visit) In-Network Out-of-Network Provider Services at Locations other than Hospital and ER In-Network Family Physician S50 \$100 \$100 \$100 \$50 \$100 \$50 \$100 \$50 \$50 \$100 \$50 \$50 \$50 \$50 \$50 \$50 \$50 \$50 \$50 \$			
In-Network \$50 \$100 Out-of-Network \$50 \$100 Provider Services at Locations other than Hospital and ER In-Network Family Physician DED + 20% \$0		DED + 40%	Not Covered
Out-of-Network \$50 \$100 Provider Services at Locations other than Hospital and ER In-Network Family Physician DED + 20% \$0		\$50	\$100
Provider Services at Locations other than Hospital and ER In-Network Family Physician DED + 20% \$0			·
ER In-Network Family Physician DED + 20% \$0		ΨΟΟ	Ψ100
	ER		
L. N. (
	In-Network Specialist	DED + 20%	\$0 Not Covered
Out-of-Network Provider DED + 40% Not Covered OTHER SPECIAL SERVICES AND LOCATIONS		DED + 40%	Not Covered
Advanced Imaging Services in Physician's Office In-Network Family Physician \$20 \$0		\$20	Ω\$
In-Network Family Physician \$20 \$0 \$0 In-Network Specialist \$35 \$0			
Out-of-Network DED + 40% Not Covered			•
Birthing Center	Birthing Center		
In-Network DED + 20% \$0			·
Out-of-Network DED + 40% Not Covered		DED + 40%	Not Covered
Diabetic Equipment and Supplies* In-Network DED + 20% \$0		DED : 200/	¢0
In-Network			
			Enteral Formulas:\$2,500 All Other:
BPM No Maximum No Maximum			
In-Network DED + 20% \$0			
Out-of-Network DED + 40% Not Covered	Out-of-Network	DED + 40%	Not Covered



	BlueChoice	BlueCare
COST SHARING	730	15
Maximums shown are Per Benefit Period (BPM) unless	PPO	HMO
noted		
Home Health Care BPM	30 Visits	40 Visits
In-Network	DED + 20%	\$0
Out-of-Network	DED + 40%	Not Covered
Hospice LTM	No Maximum	No Maximum
In-Network	DED + 20%	\$0
Out-of-Network	DED + 40%	Not Covered
Outpatient Therapy BPM (Combined Outpatient Cardiac, Occupational, Physical, Speech, and Massage Therapies)	60 Visits	No Maximum. Auth Req for Therapy
In-Network	DED + 20%	\$20
Out-of-Network	DED + 40%	Not Covered
Spinal Manipulations BPM	26 Spinal Manipulations	
In-Network	DED + 20%	\$35
Out-of-Network	DED + 40%	Not Covered
Skilled Nursing Facility BPM	90 days	90 days
In-Network	DED + 20%	\$0
Out-of-Network	DED + 40%	Not Covered
PRESCRIPTION DRUGS		
In-Network		
Retail (30 days)	045 / 005 / 040	#45 / #O5 / #40
Generic/Preferred Brand/Non-Preferred	\$15 / \$25 / \$40	\$15 / \$25 / \$40
Mail Order (90 days) Generic/Preferred Brand/Non-Preferred	\$30 / \$50 / \$80	\$30 / \$50 / \$80

^{*} Diabetic Supplies (lancets, strips, etc.) are covered under the Rx benefit except when the group carves out pharmacy. When pharmacy is carved out, they are available through DME. Diabetic Equipment (insulin pumps, tubing) are always covered under the medical benefit.

This is not an insurance contract or Benefit Booklet. The above Benefit Summary is only a partial description of the many benefits and services covered by Blue Cross and Blue Shield of Florida, Inc., an independent licensee of the Blue Cross and Blue Shield Association. For a complete description of benefits and exclusions, please see Blue Cross and Blue Shield of Florida's Benefit Booklet and Schedule of Benefits; their terms prevail.



^{**} BPM means Benefit Period (calendar year) Maximum and runs from Jan 1 - Dec 31